



Disability Resources for Students Office

Disability Verification	<i>To be completed by a certifying professional*</i> <i>(*Medical doctor or other qualified, licensed certifying professional.)</i>
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A completed disability verification form is required to determine eligibility for academic adjustments, accommodations and support services for the Clover Park Technical College student named below.

Today's Date	CPTC Student ID#	Date of Birth (mm/dd/yyyy)
Student's Last Name	First Name	Middle Initial

This section to be completed by a certifying professional

Yes No **Is the above named student currently under your care?**
If not, when did you last provide services to this student? _____

Disability is:	<input type="checkbox"/> Observable	Disability is:	<input type="checkbox"/> Permanent/Chronic
	<input type="checkbox"/> Not Observable		<input type="checkbox"/> Temporary; expected duration:

Diagnosis and description of disability(ies):

Prescribed treatments/medications:

Side effects of medication which may affect academic functioning:

DSM IV-R or succeeding equivalent, as appropriate:


Axis I
Axis II
Axis III
Axis IV
Axis V

Impact on Major Life Activities: Please check all that apply

Activity	Mild	Mod	Severe	Other			
Breathing				Chronic Pain		Easily Fatigued	
Paying Attention				Anxiety		Easily Overwhelmed	
Interacting				Panic Attacks		Impulsive	
Processing				Agoraphobia		Easily Distracted	
Reading				Other:			
Remembering							
Self-Care							
Sitting							
Standing/Walking							
Speaking							
Writing/Fine Motor Skills							
Hearing				db loss:	Left _____	Right _____	
				Comments:			
Vision				Visual Acuity	Left _____	Right _____	
				Field	Left _____	Right _____	
				Comments:			

Please sign below as the certifying professional

**If someone other than you determined the diagnosis, please include their information below*

Printed Name of Certifying Professional				 <p>Disability Resource for Students Clover Park Technical College 4500 Steilacoom Blvd SW Lakewood, WA 98499-4004</p> <p>Telephone (253) 589-5767</p> <p>Fax (253) 589-5852</p> <p>Email: DisabilityResources@cptc.edu</p>			
Title		License #					
Signature		Date					
Address							
City		ST	Zip				
Telephone (please include area code)		Fax (please include area code)					
*Diagnosis made by (if other than certifying professional please print name & title):							
Address							
City		ST	Zip				
Telephone (please include area code)		Fax (please include area code)					

